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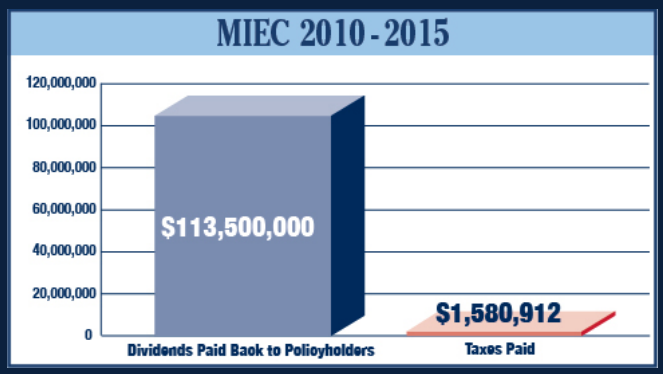

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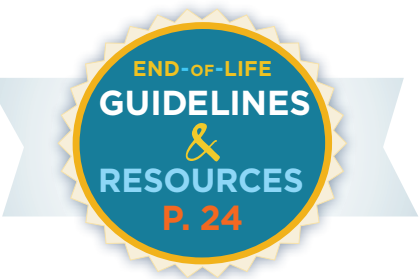

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EDITORIAL

Death, Dying, the Grim Reaper . . . and Woody Allen

Howard Daniel

Filmmaker Woody Allen once remarked, "I don't want to achieve immortality through my work. I want to achieve it through not dying."

If that thought elicits even a flicker of a smile on the face of anyone reading this editorial, then this issue of *Marin Medicine*—whose featured topic, Death and Dying, is inescapably depressing—will have unexpectedly opened on a less gloomy note.

While the next seven articles offer virtually nothing mirthful (except for a few grins in Dr. Sal Iaquinta's review of *Working Stiff*), their authors do give readers any number of heartening thoughts. Such as, for example, in their discussions of the End of Life Option Act, the wondrous benefits of hospice care, end-of-life planning, and progress in learning to ease, for patients and their families, the last hours of life.

None of this affects the inevitability of death, of course, but it might be argued that the efforts described in the following articles to soften—in various ways—the end-of-life transition represent significant progress as compared with the way death was handled not too many years ago.

Of course, the contemporary "American way of death" is often negatively compared with the good, old-fashioned—and perhaps somewhat idealized—way in which some people used to pass away (and many of those in hospice care now do): in the comfort of their own home and bed, surrounded by loving family members. What such critiques, stingingly accurate in many respects, sometimes overlook are the enormous advances that modern medicine brings to the alleviation of the dreadful suffering that too often precedes the arrival of the Grim Reaper.

Also frequently overlooked in critiques of the way we die is the breathtaking rise in lifespan wrought by advances in public health and modern medicine. While dying patients often pray for the Grim Reaper's speedy arrival, we all welcome the decades-long delay with which he makes his appearance in modern times and in economically advanced countries, as compared to the early age at which he used to appear. In Hippocrates' day, life expectancy at birth is estimated to have been about 30 years. In ancient Rome, those who didn't die in childhood could expect to live to their late 40s. In the United States, average lifespan—now in the upper 70s, depending on socioeconomic circumstance—rose by more than three decades over the course of the 20th century.

A friend mordantly observes that life is a mortal condition. Today, it might ironically be added: perhaps only in our lifetime! And Woody Allen's. Who knows what the future will bring!

Shifting gears briefly, following is a short preview of the rest of this issue. Dr. Kristen Brooks begins with a survey of the pros and cons—and protections for physicians as well as patients—of the End of Life Option Act, which enters into force on June 9, almost simultaneously with the publication of this issue. Dr. Raymund Damian discusses end-of-life planning and care. Hospice care is sensitively and touchingly treated in an article by Dr. Molly Bourne. Dr. Scott Schmidt tells us about the RESPECT Project for patients going through end-of-life transition, which he helped develop for Kaiser San Rafael Medical Center. "Everything you ever wanted to know about death certificates, but were afraid to ask" would be a good alternative title for an article by Dr. A. Jay Chapman. Following these articles is a two-page spread on CMA end-of-life resources.

The issue's Out of the Office article, by Dr. John Maa, provides a somber look at a different aspect of death and dying. It is a retelling of a suicide and its aftermath that he chanced to witness at the Golden Gate Bridge. Dr. Sal Iaquinta then gives us engaging reviews of a pair of books: *Working Stiff* and *When Breath Becomes Air*. The theme concludes with "From Death to Medical Satire," a report on the 2016 Health Care Leadership Academy.

Four upbeat articles complete the issue: Dr. Matt Willis brings us good news about the upward trend in the Marin County vaccination rate. Dr. Gregg Tolliver provides an update on the transformation of Marin General Hospital. Dr. Peter Bretan gives us a report on last November's AMA House of Delegates meeting. And MMS Executive Director Cynthia Melody closes with a tour through *Marin Medicine*'s metamorphoses over six decades. Worthwhile reading, all of it. ◆

Mr. Daniel edits Marin Medicine.

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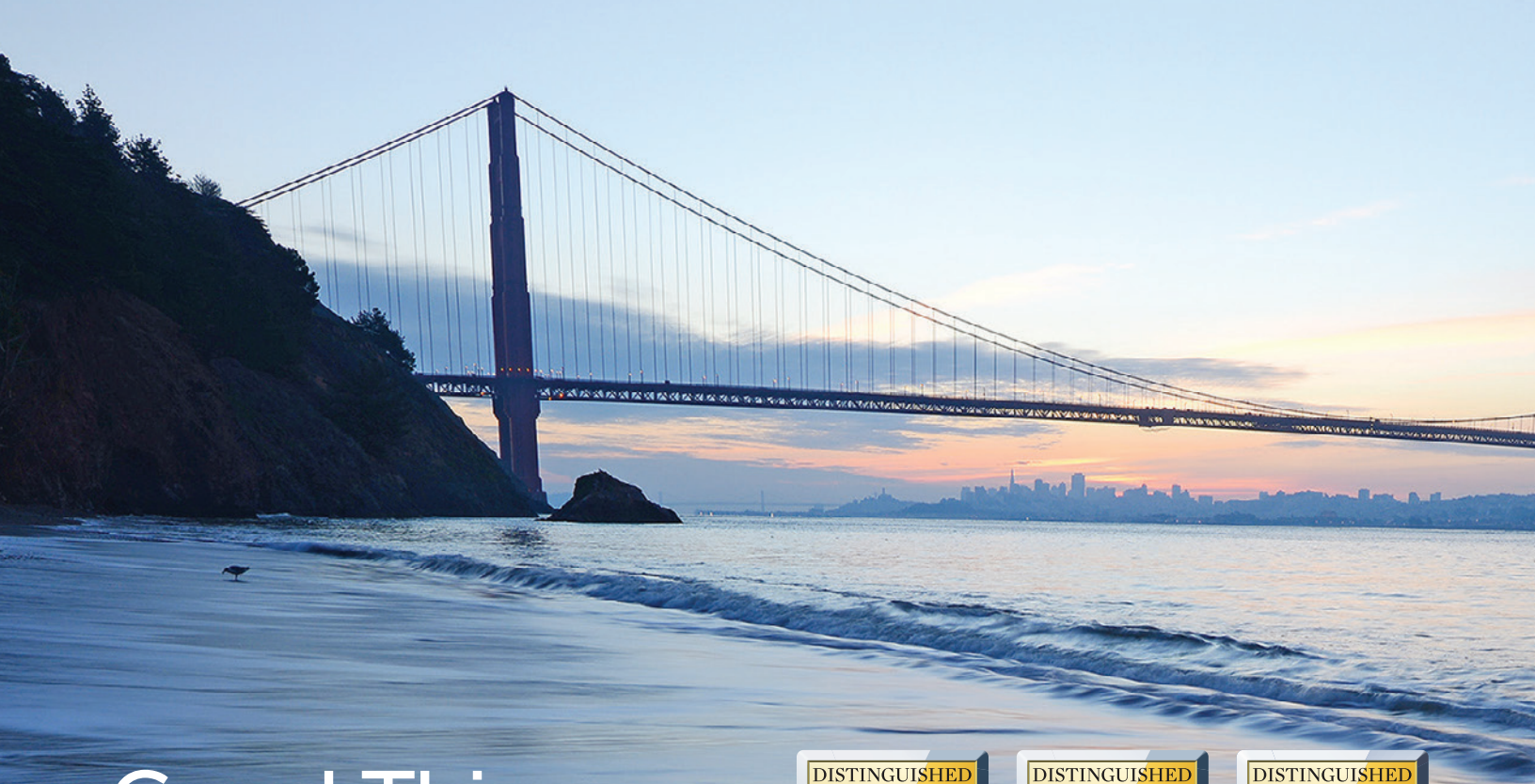

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The Pros, the Cons, the Protections for Patients and Physicians

Kristen Brooks, MD

I knew what she was going to ask me even before the words came out. Though young, she had been struggling for months with pain and debility on top of years of fighting to live. She was tired of struggling and terrified of dying on any terms but her own. "What if I want to choose when I die?" she asked. "How would it work with that new law? Who do I even talk to about this?" And so began our discussion of her options, including the option to end her own life.

The End of Life Option Act is a new law—signed by Governor Jerry Brown in October 2015 and taking effect June 9, 2016—that allows physicians to provide a competent and terminally ill patient a lethal dose of a medication for the purpose of ending his or her own life.[1]

Physician aid in dying, formerly called physician-assisted suicide, does not equate to euthanasia, to withdrawal of life-sustaining treatment or to palliative sedation (none of which, I hasten to add, are comparable to each other). Neither does physician aid in dying refer to the "double effect" of hastening death by adequately controlling pain or discomfort at the end of life. The law is very clear that this is not suicide, but patients and physicians are sometimes not entirely comfortable with this distinction, and certainly there are complex ethical issues on both sides of this law.

There are strong ethical arguments in favor of this legislation. Patient autonomy is a proud hallmark of the American medical system. We value a patient's right to choose, given the capacity to do so, the nature and course of their treatment as guided by their own personal values and morals. As Governor Brown said in his remarks on signing the bill (photo above),

> I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others.

For the purpose of relieving unnecessary anguish, we allow patients to refuse or withdraw life-sustaining treatments knowing that this will result in death. Is it so different to allow patients to end their suffering actively rather than passively? Compassion dictates that we alleviate distress for our patients, and we have all seen the suffering that comes as some patients near the end of life. Pain, indignities, confusion, agitation and fear are all unfortunate realities for many patients in their final days.

Having open and honest conversations with our patients about death and their choices promotes honesty and transparency in the physician-patient relationship. The reality is that for decades, and really centuries, patients have planned ways to end their life if suffering becomes too great. Instead of these choices being pushed into the shadows, California patients can now have open and honest discussions about ways to take control of their own death and know that if they choose to end their life, they can do so in as controlled a way as possible.

Compelling as these arguments are, there are strong and reasonable ethical arguments against physician aid in dying. On a very fundamental level we can all acknowledge that there is a sanctity to life. Lives are of value and purpose, and many people believe that it is not in our purview to determine when that purpose has ended. The act of deliberately ending one's own life is often seen as different from refusing life-sustaining treatment and letting nature take its course—a more passive action.

Critics argue that it is not our role as physicians to facilitate death but rather that the integrity of our profession is rooted in the fight against disease and the easing of suffering as disease eventually

Dr. Brooks is a psychiatrist focusing on consultation-liaison psychiatry, in particular delirium. She is co-chair of the Kaiser San Rafael Medical Center Ethics Committee.

wins. Several groups representing those with physical and cognitive disabilities, the elderly and the dependent express concern that these vulnerable groups might be taken advantage of and that decisions about the end of life might be made for them rather than by them.

The law is very clear in this regard. The decision must be by patients themselves—and without undue influence. But how do we ensure this? Further, we must acknowledge that our profession is fallible and we sometimes get things wrong. Patients get well that we never thought would recover, and prognostications for how long a patient will live can be woefully incorrect.[2] These inaccuracies and uncertainties are part of the job, but when one is involved, however indirectly, in a life-or-death decision, the stakes grow much higher.

Among the new law's many challenges for physicians is the change in how we talk with our patients. We are accustomed to having complex discussions about medical diagnoses, treatments and difficult decisions. This law creates a situation in which we talk with patients not just about our objective knowledge and experience but about ethical issues and perhaps even our personal moral beliefs. These may be difficult, and perhaps uncomfortable, conversations to have, especially when patients' stances on this law and these issues differ from our own.

The law protects the personal values of both physicians and patients in two ways. To protect patients, physicians are prohibited from presenting this, on their own initiative, as an option to patients. The law is very clear that any discussion about this option must be initiated by the patient him- or herself without any undue influence by family, physicians or care providers.

To protect physicians, there is no obligation to participate in any activity (e.g., prescribing medications) that would follow from a patient's decision to end his or her life. If doctors choose not to participate, they are obligated only to refer patients to someone who will. While these protections are important, this also means that physicians and patients who may have been working together for decades will have to part ways in this, a patient's most difficult and vulnerable hour. Furthermore, this creates a new way in which our personal values affect how we work together with colleagues, as patients move between providers who participate and those who do not.

There are several additional protections for patients and physicians inherent in this law. A sunset clause is built in whereby this law ceases to be operative in 10 years, forcing legislative re-evaluation and action—extending or amending it, or allowing it to die—depending on how it is seen to have served its intended purpose. The goal is to protect against abuses and avoid the "slippery slope." The reality is that despite the fear, that slippery slope has not been a problem in Oregon, a state that now has 15 years of experience and on whose laws the California legislation was based. Patients rarely ask for assistance in dying—less than 0.05% of deaths follow from physician aid. Demographically, those who make this choice are similar to those who do not in terms of sex, race, health insurance coverage and hospice enrollment. Notably, those who opt for physician aid in dying tend to have higher levels of education.[3]

Ultimately, decisions at the end of life are deeply personal and should be made in partnership with a trusted physician. As physicians, we strive to provide our patients the best possible quality of life while respecting their individual choices and values. This law provides one more option in that process, and we hope it will offer comfort to those facing their final days. ◆

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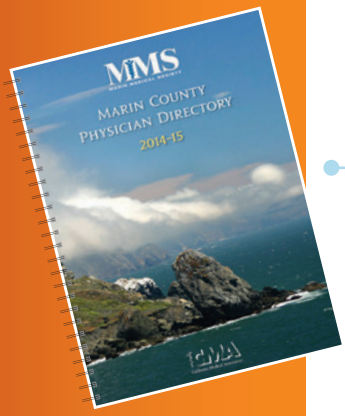

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Thinking Ahead About End-of-Life Care

Raymund Damian, MD

Recent advances in medicine are vast and amazing. Beginning with medical school, physicians are trained to save lives. Ongoing medical research seeks and finds treatments that decrease risks for chronic medical conditions, develops surgical procedures to correct physical anomalies, and creates cures for cancer. If patients are ill, the medical profession concentrates its efforts on finding ways to cure them and, in the most serious cases, to prolong and save their lives. A challenge that physicians face is how best to deliver care when all reasonable life-prolonging treatments have been exhausted or when terminally ill patients have decided not to pursue further therapy.

In 2015, the end-of-life discussion came to the forefront in California with the Legislature's passage—and Governor Jerry Brown's signing—of the End of Life Option Act. The new law comes into effect on June 9, 2016. It allows physicians to go beyond providing comprehensive information and counseling to terminally ill patients regarding end-of-life options, which have traditionally been limited to palliative treatments. It now also allows physicians to accede to the request of such patients to be helped—with the prescription of an aid-in-dying drug—to end their lives when they choose.

Dr. Damian is co-MD lead of the Life Care Planning Program at the Kaiser San Rafael Medical Center.

Whether people agree with the principles and intent of the law, they are now having an open dialogue about end-of-life. A 2012 report by the California Healthcare Foundation showed that 79% of patients wanted to talk to their physicians about end-of-life issues, but only 7% of them actually did.[1] Physicians have been reluctant or unable to have these discussions for a variety of reasons, but now they have a responsibility, and more importantly, an opportunity to do so.

But even before such delicate and in-depth end-of-life conversations occur, the medical community has a responsibility to inform patients about advance care planning and engage them in it early on. Patients have their individual paths of health and trajectory of life. Discussing advance care planning more "upstream" can significantly affect how patients view and choose their care well in advance of death's becoming imminent.

Advance care planning is a systematic approach that encourages patients to reflect on their values, beliefs and goals regarding a healthy life and to decide how medical care should be delivered when life's trajectory is altered. Since 2013, Kaiser Permanente Northern California has implemented advance care planning through its Life Care Planning program. This program is a three-step staged approach that allows adult patients to make important medical decisions in advance of need. It encourages them to have an open dialogue with their physician and to share their decisions with family and friends.

The initial phase of the Life Care Planning program is called First Steps: My Values. Patients reflect upon and choose a reliable health care agent—a person whom patients trust, who will respect their values and wishes, and who can make sound medical decisions at difficult times. A result of First Steps is the completion of a thoughtful advance directive.

The second stage (Next Steps: My Choices) invites patients with chronic progressive medical conditions who have had a significant functional decline in their health or a prolonged hospitalization review their goals regarding future treatment options. Along with their health care agent, patients reflect on and discuss a series of medical scenarios that might prevent them from returning to their baseline of good health. The product of Next Steps is a Treatment Preference document.

The final stage (Advance Steps: My Care) helps patients who are frail and elderly or have a life-limiting illness to reflect upon care when life-sustaining treatment options need to be addressed. Based on this discussion, patients and physicians complete a Physician Orders for Life-Sustaining Treatment (POLST) document.

With the End of Life Option Act, physicians now have an added layer of complexity to consider when terminally ill patients voice their wish to die on their own terms. Kaiser Permanente Northern California recognizes this legal responsibility and is actively engaging in conversations and meetings to develop and implement policies and procedures that will respect and honor such requests.

In addition to having these rich conversations in all three steps, an important component of the Life Care Planning program is to collect these medical decisions and completed documents to make them easily retrievable in patients' electronic medical records for review and future use. Advance care planning should be a partnership between patients and the medical community. The goal of Kaiser Permanente Northern California is to educate all physicians and staff about Life Care Planning and encourage them to discuss advance care planning with all adult patients who visit any Kaiser Permanente medical center.

To date, a review of the Life Care Planning program at Kaiser San Rafael has resulted in 1,426 First Steps encounters, 92 Next Steps conversations, and 1,030 Advance Steps (POLST) discussions.[2] The Life Care Planning program is an active component of patient care throughout the medical care continuum. The hope is that all health plans in Marin County will adopt and implement their own advance care planning program so that every adult patient's medical decisions are honored and acted upon with respect. ◆

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Hospice Is Plain Good Medicine

Molly Bourne, MD

Death is not optional. Even in Marin. Talking to patients about their options at end of life is part of a physician's commitment to excellent care. It is not a question of whether our patients will die. They will. Nor is it about whether they want to die. They don't. It is about providing good medical care to people in their final years.

When I hung my shingle in Point Reyes 17 years ago, I thought the Hippocratic Oath meant I would keep people from dying. So long as I knew how to discuss when to have a colonoscopy and the risks and benefits of Lipitor, I figured I could safely "do no harm." But when I met my patients, I discovered only some of them had high cholesterol, and even fewer, colon cancer. Yet, all of them would eventually die. It struck me then: I was a full-fledged physician with no training in the one thing that would affect every single one of my patients.

Dr. Bourne is chief medical officer of Hospice by the Bay.

Of course, in medical school I saw people die. I stared in fright at their grieving families, then at the body in the morgue and finally at a daunting crowd of physicians in Grand Rounds. We all wanted to know how the death could have been prevented—what we had missed, or worse, done wrong. Certainly, no one suggested how the death might have gone better. Nor did it occur to me that this person might have preferred to die somewhere else, accompanied by someone he or she actually knew. Honestly, in my exposure to death during training, I was most aware of wanting to be somewhere else myself.

For this reason, those first few years in practice were the most humbling in all my training. In particular, the education I received from Hospice of Marin (now Hospice by the Bay) provided the biggest lessons. I don't recall exactly how I started referring patients. It was likely someone else's idea, perhaps a desperate family member or an experienced caregiver. But before long, I found myself with a handful of patients who, in addition to my care, had a transdisciplinary hospice team visit them at home. This close surveillance ensured early symptom management, medication compliance, family support and patient-centered education. The team members knew what to expect, what to say and what to do. With both chagrin and excitement, I saw excellent end-of-life care for the first time.

More humbling though was that a substantial number of my patients were actually discharged from hospice alive. The team's good old-fashioned medical care seemed to lengthen prognoses, in some cases beyond six months (the hospice benefit cutoff). Ironically, my patients flourished with end-of-life care. Furthermore, when I gave my "graduating" patients the good news that they didn't need hospice

Dr. Molly Bourne (right) confers with Anitra Palmer, intake nurse at Hospice by the Bay.

anymore, they begged for the team to keep coming. These patients had initially feared hospice, thinking it would hasten death with drugs like morphine. Yet now they were enjoying better quality and quantity of life and, at this rate, could not imagine letting go of the hospice benefit.

Sheepishly, I began studying hospice care in earnest. I discovered studies that show that patients on hospice, regardless of diagnosis, live weeks to months longer than patients without hospice.[1] In addition, they rate their quality of life higher, spend less of their last six months in the hospital, have fewer invasive procedures and cost less to insurance providers.[2] Fifteen to 20% of patients are discharged from hospice alive (and improved) because of the attentive medical care from the transdisciplinary team.[3] Hospice is a Medicare and Medicaid benefit and is also covered by most medical insurance plans. At Hospice by the Bay, services are provided regardless of insurance coverage, citizenship, housing, caregivers or code status.

A free service that allows patients to live longer and better? Why had I not heard about this before? I was now prepared to refer everyone who was eligible.

Then came the final discomfiting jolt to my ego. One of my patients, a man in his 50s with cardiomyopathy, died while considering participating in a heart surgery study. He was survived by a wife and son. Privately, I had known he was dying. I hadn't known when it would be, but he was short of breath at rest despite medical therapy, and he was not getting better. The surgical trial showed modest benefits for a fraction of the patients enrolled, so whether or not they accepted him, my patient had had a good chance of dying from heart disease within the next six months. But even if I had thought of referring him to hospice, I didn't want to get in the way of his hope. I didn't think he was ready to hear he was dying. I believed, and still do, that he would have preferred not knowing his prognosis.

His wife found him at home after a long day at work. She dialed 911 and then me. When I arrived, I spent the first 10 minutes of my visit convincing the police that a forensic investigation was not necessary. His wife heard me tell them that the death was expected. Through tears, she cursed all doctors across the United States who had failed her husband. More than not fixing him, she lamented, they had not told her the truth. Had she known he was dying she would have taken time off work to be with him. She didn't say it, but I too was guilty of protecting her from the truth. Later that week, their son returned from college and came to my office. Like his mother, he was careful not to blame me directly, but he also felt robbed. I was pleased that Hospice by the Bay had a community bereavement program to which I could refer them both; they had so much to process.

Of course, I had my own feelings to reckon with too. I knew I was not responsible for his death, yet I felt I should have said something earlier. Was hope for an improbable cure more important than a

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family's opportunity for closure? Could they have had both? Could I have offered the support of hospice without sabotaging my patient's quest for life?

Unable to sleep that night, I reread the Hippocratic Oath. Interestingly, it does not say "Do no harm." That is a myth. Rather, it includes the following promises:

1. I will not be ashamed to say "I know not."

2. I will avoid those twin traps of overtreatment and therapeutic nihilism.

3. I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being.

Around that time, coincidentally, I bought a new car, the first one I had ever owned with airbags. When I signed the paperwork, I imagined commuting to my office, taking trips with my family, and driving to home visits all over West Marin. I was thinking of where my new car would take me, not about airbags. I wasn't planning to crash, and if asked, I would have said I was not "ready" to crash. The airbags were just tucked into my new car, inconspicuous, just in case.

Perhaps sleep deprivation played a role, but something about that Greek covenant and my automobile's safety features triggered an overnight change in the way I practiced medicine. I discovered I could follow the Hippocratic directions while allowing my patients to dream about where they are going rather than about crashing. I could have frank conversations about the hospice benefit and wholeheartedly foster hope. Offering hospice was like slipping those airbags into the dashboard, just in case death is not optional. I did not ask whether the patient was ready for the conversation; I asked whether he was eligible. And when a patient's prognosis flirted below a year, I touted hospice for what it was: a team of experts that knows more about death than any of us is expected or wants to know. A team that can help navigate end of life. *Just in case.*

In medical school, I committed not just to treat people, but to treat them well, as human beings. As humbling as it had been for me as a young doctor to admit "I know not," I learned to provide the best care at end of life.

Here's what I wish I had said six months before my patient died:

On paper, you meet the criteria for the hospice benefit. This means a team of experts can come to your home and help you manage your symptoms, get your affairs in order, and provide tools for you and your family to process the incremental losses that come with an illness like yours. If you decide to do the heart surgery, you can come off hospice with no penalty. But if you don't, hospice will provide better care than I can alone because they are a phone call away anytime, day or night. I will remain your doctor, and they will keep me abreast of what is going on without your having to come to the office, which I know is getting harder and harder. And if you aren't sure you want a bunch of people coming into your house, remember you don't have to meet the team all at once, just at your convenience. And they are as much for your wife and son as for you. I think it is a good idea to do this now, when you are doing well, because the better the hospice team knows you, the better they do their job. And if you get your heart surgery—when you get your heart surgery—should something go wrong, hospice can sweep back in, already aware of who you are and what your goals are. Just as you might hire experts to help with your taxes, to educate your son in college, or even to train your dog, hospice is the expert for this part of your medical care. And to be honest, I wish all my patients could have this service. It is just plain good medicine. ◆

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RESPECT at the End of Life

Scott Schmidt, MD

It was a busy Saturday night at Harbor UCLA Medical Center just outside South Central LA. A young man arrived in cardiac arrest after multiple gunshot wounds to the chest, and despite our best efforts he died. After the code, I ran through what we did in my mind. We'd made all the right moves. I knew we'd done everything possible to save his life. I was a second-year resident, and I was learning to take the lead.

The last thing on the list, of course, was to tell the shooting victim's wife that he'd died. I was on my way to speak with her when a senior resident pulled me aside and said, "The conversation you are about to have is all that matters right now."

It was a teachable moment and he was absolutely right. Unfortunately, that was the full extent of the training I received during residency in being with death and dying. The emphasis was on saving lives—not on how to speak and be with patients and families at the end of life. That experience and a constellation of others around that time led me down a path of ever-deepening interest and passion to learn more. It is now 20 years since that night, and what follows is part of what's come out of my journey down that path.

Dr. Schmidt is an emergency physician with a subspecialty in hospice and palliative medicine at the Kaiser San Rafael Medical Center.

The RESPECT Project is an interdisciplinary approach to death and dying that we first implemented in the Emergency Department at Kaiser San Rafael in December 2013. It is a distillation of some of what I've learned in 20 years as an ED physician and 10 as a hospice and palliative medicine physician. It is by definition interdisciplinary because it takes the entire health care team to do this work well, and it provides a set of tools intended to help providers of all types care for the dying and their loved ones. With the support of the Kaiser San Rafael Medical Center physician leadership, the ED nurse management team, and the many compassionate colleagues I have the honor of doing this work with, the project has helped shift the culture around death and dying in our ED.

And throughout our hospital. The RESPECT Project has since been adopted hospital-wide as an approach to death and dying and has been expanded to include information for families about the dying process—a list of bereavement resources, a quick info card, and expanded nursing resources information including a comfort care manual and a guide to relevant community resources.

The RESPECT Project consists of the Emergency Department Comfort Care Protocol (EDCCP) and the RESPECT Practice Tool (both on page 19). The EDCCP pertains to imminently dying patients (prognosis of hours to days) for whom treatment goals are comfort-focused only. It emphasizes the importance of both pharmacologic and non-pharmacologic means of promoting comfort and minimizing suffering, and it establishes a method for nonverbally communicating to all staff that a patient is in the process of dying. When an imminently dying patient whose treatment goals are comfort-focused only presents to the Emergency Department, the attending physician initiates the EDCCP with a Nursing Communication Order listing a series of suggested interventions and orders appropriate medications for symptom management.

The RESPECT Practice Tool is used when a patient dies, whether unexpectedly

or as the natural conclusion of a terminal illness or a long life. It provides a structured approach to what can be an emotionally and professionally challenging experience. When a death occurs, the RESPECT Practice Tool helps support providers care for the patient and his loved ones in the best way possible.

In the RESPECT acronym, the **R** stands for **Restore Order.** A nurse colleague tells the story of having cared for a teenage girl killed in a motor vehicle accident whose father tearfully asked as he cleaned the blood from his daughter's face, "Why am I the one that has to do this?" In some cases, the way a dead or dying patient looks when the family is brought to the bedside is how she will be remembered for the rest of their lives. Cleaning vomit from a patient's face or removing unnecessary medical equipment or trash from the resuscitation suite is not to pretend death hasn't happened. Rather, it is one small way we can respectfully begin to put the pieces back together just as the family will have to do in the months and years ahead.

The **E** stands for **Explain What Happened and Who Was Involved.** In some cases, providing information about what happened between when Mom collapsed and when resuscitation efforts stopped and about who assisted with her care can be helpful to those who've suffered a loss. But it is useful to ask permission before providing such information, since it's important not to get mired in details that can stand in the way of the emotions we are seeking to make space for.

The **S** stands for **Stop and Set Aside Other Activities.** Perhaps this should go without saying, but I know I still sometimes forget to hand off my phone when doing this kind of work. This is also a reminder to nurses to get a manager or other team member to look after his or her other patients in order to give full attention to the family and loved ones involved. This work can and should be considered higher priority with appropriate adjustments in nurse-to-patient ratios to ensure the work is done well.

The **P** is to remind us to be **Present.** Individuals facing the loss of a loved one deserve our undivided attention. Cultivating presence, especially in the face of another's suffering, requires practice. To simply bear witness can be profoundly healing.

The second **E** stands for **Empathy.** Staff are reminded to step out of their roles and imagine what the people they're caring for are going through. A dear friend of mine whose daughter tragically drowned many years ago said to me, "There is nothing anyone could have said or done that could possibly have made it OK." A willingness to imagine what it's like, to open our hearts to what is part of our shared human experience, is sometimes all we can offer.

The **C** stands for **Chaplain/Clergy** and it reminds us that for some, spiritual support is the most important support needed around the time of death. In addition to soliciting religious or spiritual help if desired, our hospital social workers also provide psychosocial support in many cases.

The **T** stands for **Time.** Family and loved ones are encouraged to take as much time as they need with their loved one. One family not long ago wanted to hold vigil for several hours even though the Emergency Department desperately needed the bed. Nurses, managers, clerks, maintenance staff and the chaplain all collaborated to find, clean and make available a vacant room elsewhere in the hospital so as to honor the family's wishes.

The **T** also stands for **Take Care of Each Other.** After bringing our full selves to the task of caring for a patient who has died and her loved ones, it is essential that we take care of each other.

Whether a patient is imminently dying on comfort care or has died, the RESPECT Project Placard is placed outside the room. This beautiful image (page 17) serves as a visual reminder of the important transition occurring inside. On the back of the Placard both the Comfort Care Protocol and the RESPECT Practice Tool are outlined for quick review. The primary nurse involved is temporarily relieved of other duties and the entire interdisciplinary team shares in the responsibility of caring for the patient and his or her loved ones at this difficult

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RESPECT Project: Kaiser SRF ED

Emergency Department Comfort Care Protocol (EDCCP):

- Goals of care for an imminently dying patient (hours to days) are established as comfort measures only
- Post RESPECT Project placard outside patient's room to advise all ED staff of the important transition occurring for patient/loved ones in the designated room
- Place patient in private room and provide seating for family/loved ones whenever possible
- Provide compassionate and empathetic bedside presence and support whenever possible
- Discontinue routine vitals. Note: VS not indicated after medications in this exceptional situation
- Remove all unnecessary medical equipment not directly related to patient's comfort or agreed upon limited interventions
- Avoid blood draws
- Adjust room temperature per patient and family request
- Provide warming blanket, dim lights, lower bed, offer food/drink as appropriate
- Encourage family/loved ones' presence at bedside
- Offer telephone for family use while in ED
- Offer to contact chaplain if available or spiritual care provider of patient or loved ones' choice
- Recognize nonverbal signs of pain or distress: furrowing of the brow, facial grimacing, calling out, tensing muscles, agitation; may use Health Connect Pain Assessment Tool for Nonverbal Patients
- Reassess every 30 minutes and after each intervention and document response to treatment
- Inform physician if symptoms not well controlled or patient appears in distress

RESPECT Practice Tool: An Approach to Death in the ED

- **R: Restore Order** (and prepare loved ones for coming to the bedside).
- **E: Explain:** What happened and who was involved in patient's care.
- **S: Stop and Set Aside Other Duties:** Other things can wait.
- **P: Be Present:** Give your full awareness to what's unfolding before you.
- **E: Empathize:** Take a moment to acknowledge that a life has just ended.
- **C: Chaplain/Clergy:** Offer to call for spiritual support.
- **T: Time:** Allow family time with their loved one before moving on to other business.

★ Designate a point person primarily responsible to loved ones' needs if possible.

★ After taking care of the patient and family, be sure to take care of each other as well.

★ Refer to RESPECT Practice Tool Narrative for further discussion.

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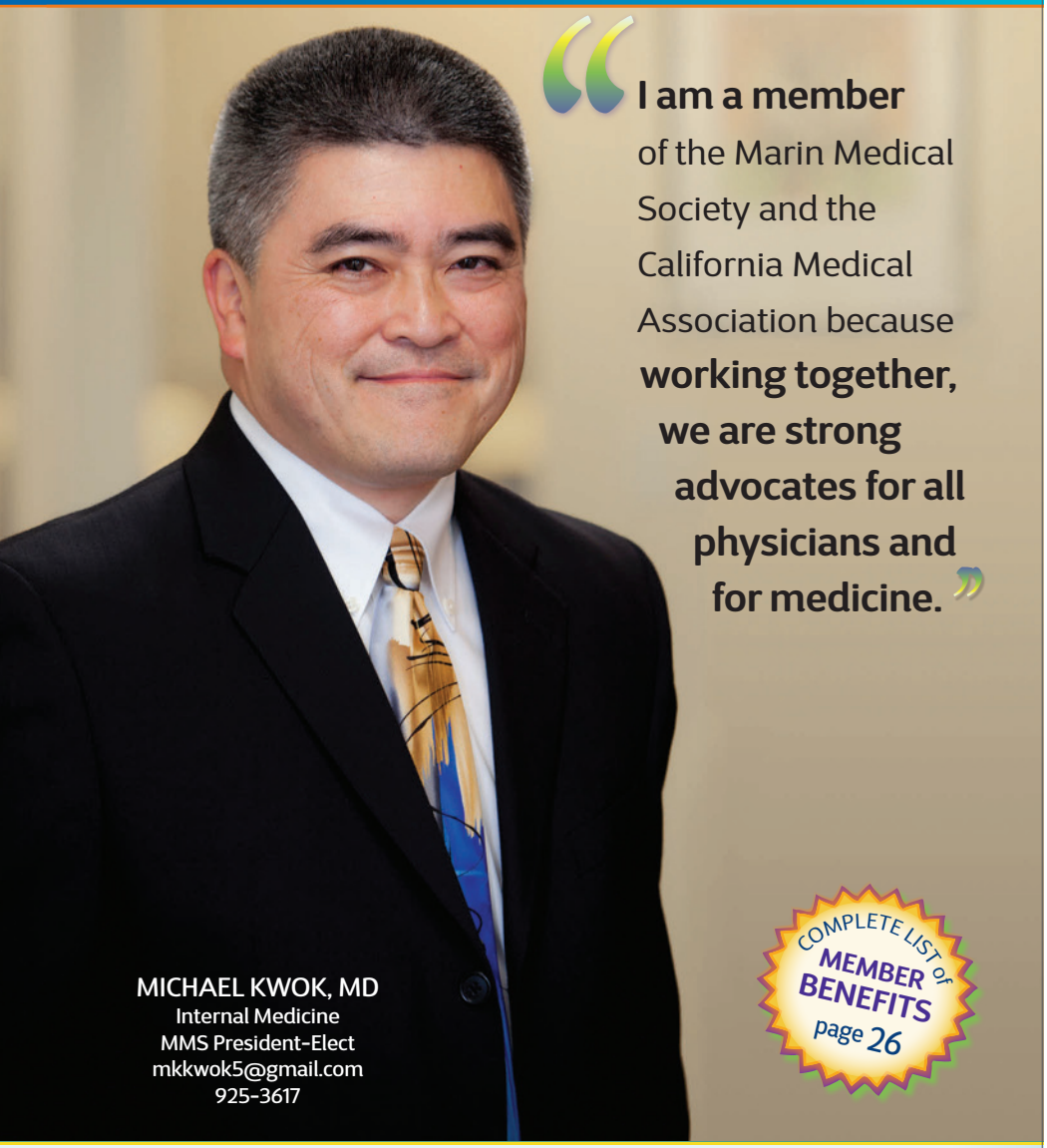
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time. While many of the interventions proposed in the EDCCP and the reminders outlined in the RESPECT acronym are common sense and might arguably happen naturally, consistently caring for the dying according to the principles of the RESPECT Project in the midst of a busy Emergency Department is easier said than done. The RESPECT Project Placard on the door helps everyone remember what's important during an experience that survivors will remember for the rest of their lives.

In addition to early training of all staff, several nurses did further training and became Palliative Care Nurse Champions. They serve as a resource for any questions that arise and model the kind of care the RESPECT Project seeks to promote. We periodically bring in professional actors to help in communication training for physicians, with the actors in the role of family members going through the labyrinth of late-stage illness and death. We all understand that this is not the kind of thing one masters quickly, if at all. It is deeply humbling and is some of the most meaningful work we do.

One incident stands out in my mind. I was caring for an extremely elderly man with Parkinson's disease and dementia presenting with recurrent pneumonia and sepsis. His family arrived soon after he did, and I learned that the patient had been a musician. His family was absolutely certain that confusion and dependence on others for activities of daily living in a nursing home did not constitute a life he would want to continue. They asked us to provide comfort-focused treatment only. We removed the medical equipment from his body, adjusted the room light and temperature as his family felt best, and provided Tylenol for fever and a touch of morphine for his air hunger. The RESPECT Placard was placed on his door and all staff were made aware of what was going on. The social worker, chaplain and primary nurse supported the patient and family in wonderful and complementary ways. And as he slipped away, his family could be heard quietly singing him his favorite songs. ◆

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Certification of Death: Whose Responsibility?

A. Jay Chapman, MD

Many patients with fatal disease follow a predictable course through their illness that ultimately results in their death. Having one's patient die is always discomforting, but in most of these instances, the physician is prepared for the event. For these cases, there is almost never a question that the patient's physician is responsible for the certification of death and completing the death certificate (DC).

In addition to providing data for leading causes of death and other public health statistics, DCs most immediately allow arrangements for the disposal of the body. Thus, if the family cannot promptly obtain a valid DC, they will at a minimum be terribly inconvenienced. At the other extreme, families can even be shoved into financial ruin if the DC is delayed for a prolonged period since it is necessary for life insurance claims, pension benefits, settling of estates (wills, trusts, accessing bank accounts, real estate holdings), Medicaid benefits, and even future marriages where proving the death of a previous spouse may be necessary.

Dr. Chapman is a forensic pathologist at the Sonoma County Coroner Unit.

Some patients have risk factors for sudden demise, and their death is quite often unexpected to family, friends and physicians. The most common and obvious risk factors are hypertension, obesity, diabetes mellitus, hyperlipidemia and seizure disorders. Despite the unexpected nature of these natural deaths, nearly all are under the purview of the attending physician—not the coroner—if there are no suspicious circumstances. By statute, the attending physician must complete the DC. Physicians may not avoid this responsibility by making a "policy" that is contrary to state law.

One common misconception is that the physician must be in physical attendance at the time of death. A physician is considered to be the attending physician if the patient was being seen by that physician or designee in the physician's office or the patient's home, or if the patient was using or refilling prescriptions written by the physician. There are no specified limits as to the time when the patient was last physically seen by the physician.

Patients seen in the emergency room are a different matter. If the emergency physician only performs resuscitative measures and pronounces the patient dead—and the emergency physician was not otherwise seeing the individual as a patient—he or she is only the "pronouncing" physician and is not responsible for completing the DC. The responsibility for death certification still falls to the physician who has been treating or "attending" the patient, provided the death is due to natural means and didn't occur under valid suspicious circumstances.

In some cases, the emergency physician diagnoses and treats a natural illness unrelated to trauma or suspicious means. If the patient succumbs to that illness, the emergency physician is responsible for signing the DC, regardless of any "policy" established by the hospital or other entity. In these cases, the emergency physician is considered to be the attending physician, no matter how long he or she has been treating the patient.

The Coroner's Role

California law specifically provides that the coroner has the discretion to determine the extent of inquiry to be made in any given case. The law further provides that if the inquiry determines that the "physician of record" has sufficient knowledge to reasonably state the cause of death, the coroner may require that physician to sign the DC.

The coroner is notified in most cases of sudden and unexpected death. The case is then investigated to the extent that the coroner deems necessary. The attending

physician is responsible for completing the DC when the coroner determines that the death was due to natural causes, that there are no suspicious circumstances, that there is a physician of record, and that the death was reasonably due to a condition or conditions for which the deceased had been seen by that physician. The identity of the physician of record is determined most often via history given by family or friends or through medical records or prescriptions possessed by the deceased.

Physicians notified by the coroner's office of their responsibility to sign the DC sometimes object because they were not present when the patient died. This misconception has been discussed above and is not a valid reason for refusing to sign the DC. The only valid reason for not completing the certificate is that trauma or overdose initiated the process that led to the patient's demise, or that the attending physician is also deceased.

Some physicians believe that their simple refusal to sign the DC obligates the coroner to assume jurisdiction. In fact, the coroner is under no such obligation. The practical effect of such refusal in many instances is to create a great inconvenience for the patient's family.

Another reason given for not wanting to complete the DC is that the physician cannot state the exact cause of death. An exact cause of death is not required on the DC. The DC only requires that the cause of death be based upon reasonable medical probability. If the physician feels more comfortable doing so, he or she can qualify the cause of death with a modifier such as "probable."

Autopsies

Some physicians may believe that their absolute or adamant refusal to sign the DC will result in an autopsy; but that is highly improbable. What is much more likely to happen is the following:

- Taxpayers will incur considerable expense for bringing the body to the morgue, where an autopsy is unlikely to be performed. Instead, the pathologist will only undertake an external examination of the body.
- The family of the deceased will be inconvenienced and may have to pay an increased fee for the funeral home to retrieve the body from the morgue.
- The cause of death will be determined by the pathologist who examines the body.
- The pathologist will determine the most probable cause of death by investigating the circumstances of death and the medical records. These records will be subpoenaed by the coroner and must be provided from the physician's office or other treatment facility—another inconvenience and expense for the physician or facility.

In these cases, the attending physician is in a much better position to provide the medically probable cause of death, thereby eliminating the inconveniences and expenses that are otherwise involved. The coroner's office does not exist to provide autopsies that should properly be done by hospital or private pathologists.

If the coroner notifies you, as the attending physician, that your patient has died, that the death has been investigated, and that the death is due to natural means, you should have no hesitancy in completing the DC—unless you know of some valid circumstance that the coroner did not investigate. I don't know of any case in which a physician has been sued for a cause of death stated on the DC.

Another misconception regarding the DC is that it may be signed at your leisure. California law provides that the DC must be signed and made available to the funeral director no later than 15 hours after the time of death.

Bear in mind that if you have been treating a patient for a potentially fatal condition, you have obviously been billing with a code for that condition. It goes without saying that if you are capable of billing for the patient's condition, you are quite capable of placing that condition on the DC!

Completing the DC

The cause of death is the disease, injury or abnormality that, either alone or in combination, caused the sequence of events that ultimately led to death. The terms initiating, proximate or underlying cause of death may also be used—all with the same meaning. In assigning a cause of death, you should use a simple statement of the underlying cause: the event without which the chain of events leading to death would not have occurred.

The mechanism of death is the process by which an organ or organ system fails when there is fatal disease, injury, abnormality or chemical insult: the pathophysiologic change(s) set in motion by the cause of death. The mechanism of death represents the physiologic or anatomic change that is incompatible with life after the body sustains a lethal event. For instance, a dissecting aneurysm of the aorta may cause a laceration of the aortic wall and produce massive hemopericardium with cardiac tamponade, followed by brain death due to anoxia. Death in this case was due to 1) hypoxic/anoxic encephalopathy due to 2) circulatory failure due to 3) cardiac tamponade due to 4) massive hemopericardium due to 5) aortic wall perforation due to 6) dissecting aneurysm of the aorta. All of the "due to's" except the sixth are mechanisms of death. The sixth and final due to is the cause of death.

Manner of death must be distinguished from cause of death. The man-

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ner of death designations specify how the cause of death came about. The designation can refer to social relationships and personal causation. The customary designations are natural, suicide, accident, homicide, undetermined and pending. A special designation for people dying from military actions is operations of war—with the exception of situations arising in military actions that constitute homicide.

In California only the coroner or medical examiner can certify deaths in which the manner of death is other than natural. Any physician who treats a victim of gunfire, blunt force trauma, poisoning, sharp force injury, or any other kind of violence—or whose death occurred under suspicious circumstances—cannot certify the death and is required to notify the coroner.

Sometimes the underlying cause of death may be overlooked but should properly require that the coroner be notified. A few examples are 1) sepsis due to decubitus ulcers due to paraplegia due to remote gunshot wound to spine; 2) pneumonia complicating acute ethanol or drug toxicity; 3) seizure disorder due to closed head injuries due to remote motor vehicle accident, blow to the head or a fall; 4) anaphylaxis due to bee sting; 5) pulmonary thromboembolism due to deep vein thrombosis due to hip fracture due to unwitnessed fall; 6) pneumonia complicating subdural hematoma due to trauma.

Helpful Hints

When completing death certificates, the most important thing to remember is that the statement of the cause of death most often should not include the mechanism of death, although it is sometimes employed for clarity in a particular situation. When the cause of death is stated, it should be the underlying cause—the culprit that initiated the entire series of events leading to death. Terms such as cardiac arrest, asystole, cardiopulmonary arrest, respiratory arrest, electromechanical dissociation and ventricular fibrillation are all mechanisms of death and cannot be used as the statement of the cause of death.

Simple statements of cause of death include:

- Arteriosclerotic cardiovascular disease
- Hypertensive cardiovascular disease
- Obesity-related heart disease
- Sequelae of diabetes mellitus
- Non-traumatic intracerebral hemorrhage

In summary, death certificates need to be as accurate as possible, and completing the DC should be accomplished with the least expense and inconvenience to taxpayers and the family. The coroner's staff, including the pathologist, are always willing to assist in completing the DC. Physicians can call the office at 415-473-6043 at any time with questions or problems that arise. ◆

For more information on completing death certificates, consult the CDC's Physician's Handbook on Medical Certification of Death at www.cdc.gov/nchs/data/misc/hb_cod.pdf.

CALIFORNIA MEDICAL ASSOCIATION

GUIDELINES

INFORMATION

to the End of Life Option Act, ABX2-15

The **California Medical Association** has published new legal guidance intended to help physicians and patients understand requirements of the End of Life Option Act. The document, #3459 in CMA's extensive On-Call Health Law Library, is in a question-and-answer format. It is available as a free download to CMA members and to nonmembers who register with **cmanet.org.** Below are the questions addressed in the 15-page guide. To download the complete Guide with answers, go to:

1. When does the End of Life Option Act become effective?
2. Who can make an aid-in-dying request under the Act?
3. How does a patient make an aid-in-dying request?
4. Are there documentation and witness requirements for oral and written requests?
5. Are there additional documentation requirements?
6. Are particular forms required by the Act?
7. Can an interpreter be used?
8. Who is a "health care provider" under the End of Life Option Act?
9. Can any physician receive a request for an aid-in-dying drug?
10. What are the obligations of the attending physician who receives a request?
11. What is required for an initial determination that a patient is "qualified" to request an aid-in-dying drug?
12. Can a terminally ill patient with a mental disorder be "qualified" to request an aid-in-dying drug?
13. Does a patient's request for an aid-in-dying drug mean the patient needs someone else to make decisions for them?
14. Are there specific requirements to ensure that the patient is making an informed decision?
15. Is a referral to a consulting physician required for every patient?
16. Does the Act contain safeguards against coercion and undue influence?
17. Will the patient be counseled about taking an aid-in-dying drug?
18. What are the final steps before an aid-in-dying drug can be prescribed?
19. How does a qualified patient obtain the aid-in-dying drug?
20. Who can be a consulting physician and what are their responsibilities?
21. Is a mental health specialist assessment required for every patient who requests an aid-in-dying drug?
22. Who can serve as a mental health specialist under the Act and what are their responsibilities?
23. Can a patient change his or her mind to use an aid-in-dying drug?
24. Does the patient have any additional obligations once the aid-in-dying prescription is written?
25. Does the Act specify what aid-in-dying drug can be prescribed?
26. What should be stated as the official cause of death on the death certificate?
27. What are the attending physician's reporting requirements?
28. What are the aid-in-dying data collection and publication requirements?

ON END-OF-LIFE ISSUES

RESOURCES

for Physicians and Patients

Contact CMA with questions about the Health Law Library or how to access documents: 800-786-4262

http://www.cmanet.org/resource-library/detail/?item=the-california-end-of-life-option-act. To download the Act itself, go to: http://goo.gl/LGhG33.

The Resources in the column at right can be found at www.cmanet.org/about/patient-resources/end-of-life-issues/.

29. **What happens to unused or excess aid-in-dying drugs?**
30. **Are physicians required to participate in the End of Life Option Act?**
31. **Are there legal protections if a physician chooses not to participate?**
32. **Can medical staff members, employees, and others be prohibited from participating?**
33. **What is considered "participation" in activities authorized by the Act?**
34. **Does the Act require notice of a prohibiting employer or health care provider's policy prohibiting participation in activities under the Act?**
35. **Are there limits on a prohibiting employer or health care provider's ability to prohibit participation in activities under the Act?**
36. **Can a physician be disciplined for violation of a prohibiting employer or health care provider's policy prohibiting participation in the Act?**
37. **Can a physician be reported to the medical board solely for violation of a policy prohibiting participation under the Act?**
38. **Are there protections and immunities for physicians who choose to participate?**
39. **What is considered criminal conduct under the Act?**
40. **How does the Act impact insurance policies and contracts?**

ADVANCE HEALTH CARE DIRECTIVE:

CMA Advance Health Care Directive Kit in English (rev. 3/14)
CMA Advance Health Care Directive Kit in Spanish (rev. 9/14)

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST):

2016 POLST form (effective Jan. 1, 2016)
CMA POLST Kit in English (rev. 12/15)
CMA POLST Kit in Spanish (rev. 10/14)
CMA On-Call #3451: Decisions Regarding Life-Sustaining Treatment—Advance Directives and POLST (2015)
CMA On-Call #3450: Decisions Regarding Life-Sustaining Treatment for Patients Without Advance Directive or POLST (2015)

DO NOT RESUSCITATE FORM:

Do Not Resuscitate Form in English
Do Not Resuscitate Form in Spanish
CMA On-Call #3453: Decisions Regarding Resuscitative Measures—DNR Requests & Orders and Cardiopulmonary Resuscitation (2015)

OTHER RESOURCES IN THE CMA HEALTH LAW LIBRARY:

On-Call #3452: Documenting Decisions Regarding Life-Sustaining Treatment
On-Call #3454: Decisions Regarding Life-Sustaining Treatment and the Patient Self-Determination Act and Joint Commission
On-Call #3455: Physician-Assisted Suicide
On-Call #3456: Responding to Request for Non-Beneficial Treatment
On-Call #3458: CMA Model Policy: Responding to Requests for Non-Beneficial Treatment
On-Call #3400: Autopsies
On-Call #3401: Organ and Tissue Donation
On-Call #3402: Pronouncement of Death and Death Certificates
On-Call #3403: Pronouncement of Death Diagnosis of Death by Neurologic Criteria

FOR PATIENTS

Coalition for Compassionate Care of California website, **www.coalitionccc.org.**
The booklet "Finding Your Way," written by the Center for Healthcare Decisions as a useful guide to thinking about and discussing end-of-life issues. To order a copy, visit the Coalition for Compassionate Care website.
POLST California, **www.capolst.org.**

MEMBERSHIP HAS ITS BENEFITS!

Free and discounted programs for MMS/CMA members

BENEFIT	PROVIDER
Auto/Homeowners Insurance *Save up to 8% on insurance services*	**Mercury Insurance Group** 888-637-2431 • www.mercuryinsurance.com/cma
Car Rental *Save up to 25%*	**Avis or Hertz** 800-786-4262 • www.cmanet.org/groupdiscounts
CME Certification Services *Discounted CME certification for members*	**CMA's Institute for Medical Quality** 415-882-5151 / www.imq.org
HIPAA Compliance Toolkit *Various discounts*	**PrivaPlan Associates, Inc.** 877-218-7707 • www.privaplan.com
ICD-10-CM Training *Deeply discounted rates on several ICD-10 solutions, including ICD-10 Code Set Boot Camps*	**AAPC** www.cmanet.org/aapc
Insurance Services *Save up to 25% on workers' comp insurance and receive special pricing and/or enhanced coverage for life, disability, long term care, medical, dental and more*	**Mercer Health & Benefits Insurance Services LLC** 800-842-3761 cmacounty.insurance.service@mercer.com www.CountyCMAMemberInsurance.com
Legal Services *FREE access to CMA On-Call (online health law library), access to CMA legal staff through the legal information line and more*	**CMA's Center for Legal Affairs** 800-786-4262 • legalinfo@cmanet.org www.cmanet.org/legal
Magazine Subscriptions *Save up to 50% on all subscriptions*	**Subscription Services, Inc.** 800-289-6247 • www.cmanet.org/magazines
Medical IDs *Discounts on 24-hour emergency identification and family notification services*	**MedicAlert** 800-253-7880 • www.cmanet.org/medicalert
Medical Waste Management *Save 30% or more on medical waste management and regulatory compliance services and 50% on the Compliance Portal*	**EnviroMerica** 650-655-2045 • www.cmanet.org/enviromerica
Mobile Physician Websites *Save up to $1,000 on unique website packages*	**MAYACO Marketing & Internet** 209-957-8629 • www.cmanet.org/mayaco
Office supplies, facility, technology, furniture, custom printing and more . . . *Save up to 80%*	**Staples Advantage** 800-786-4262 • www.cmanet.org/staples
Physician Laboratory Accreditation *15% off lab accreditation programs and services*	**COLA** 800-786-4262 • www.cmanet.org/cola
Physician Smartphone App *FREE secure messaging application*	**DocbookMD** www.cmanet.org/docbookmd
Reimbursement Assistance *FREE assistance with reimbursement and contracting issues*	**CMA's Center for Economic Services** 800-401-5911 • economicservices@cmanet.org www.cmanet.org/ces
Security Prescription Products *15% off tamper-resistant security subscription pads*	**RxSecurity** 800-667-9723 • www.cmanet.org/rxsecurity
Webinars and Seminars *CMA works with industry experts to offer timely, high-quality education programs, including FREE webinars and deep discounts on live seminars*	**CMA** www.cmanet.org/events

PUBLICATIONS

CMA Publications

http://www.cmanet.org/news-and-events/publications/

- ***CMA Alert*** **e-newsletter**
- ***CMA Practice Resources***

CMA Resource Library & Store

http://www.cmanet.org/resource-library/list?category=publications

- Advance Health Care Directive Kit
- California Physician's Legal Handbook
- Closing a Medical Practice
- Do Not Resuscitate Form
- HIPPA Compliance Online Toolkit
- Managed Care Contracting Toolkit
- Model Medical Staff Bylaws
- Patient-Physician Arbitration Agreements
- Physicians Orders for Life Sustaining Treatment Kit

MMS Publications

www.marinmedicalsociety.org

- ***Marin Medicine*** (semi-annual)
- ***Marin County Physician Directory*** (annual)
- ***MMS News Briefs*** (monthly)

CONTACT MMS/CMA: 415-924-3891 • mms@marinmedicalsociety.org

May 2016

Tale of a Suicide: A Life-Ending 'Option' We All Deplore

John Maa, MD, FACS

Wikimedia Commons (Grombo)

On the Friday evening of Memorial Day weekend in 2015, I was driving into San Francisco across the Golden Gate Bridge. Northbound traffic was heavily congested around mid-span, as the right lane was closed. Emergency vehicles with flashing lights redirected traffic to the left lanes. As I approached the bottleneck, I noticed a backpack leaning against the railing and saw two bridge security officers who appeared to be gesturing in the direction of Alcatraz. I quickly realized that they were pointing not at the prison, but instead at a person holding his head in his hands and seated on the ledge outside the railing.

I drove to the southern end of the bridge as police cars with sirens blaring raced toward the scene. I parked in the south lot, and began walking back toward Marin. The skies were gray, and the red lights of the patrol vehicles colored both the water below and the clouds above. As I approached the toll plaza I noticed a new color flickering on the water's surface. It was from the distinctive white flare that is dropped by Bridge security to mark the spot where a person has fallen and guide search-and-rescue efforts by tracking the direction of the currents.

A gray Coast Guard vessel matching the color of the sky could now be seen racing westward to the scene from Fort Baker, just past the north end of the bridge. It paused near the smoke of the flare and then continued to the other (i.e., west) side of the bridge, where it stopped and circled. It lay motionless on the water for about four minutes and could then be seen rushing back toward Fort Baker, where an ambulance was waiting. As I kept walking toward the site of the bottleneck, I saw that traffic had again begun moving normally. A grim-faced bridge security officer drove past in a small white vehicle that was otherwise empty.

I reached the site of the disturbance, which was now deserted without any trace of the preceding events. As I turned and walked back to San Francisco, I passed joggers, pedestrians and tourists who likely knew nothing of what had just taken place. On returning to the south plaza, I noticed that the ambulance had not left Fort Baker.

I had with me the trauma surgery call pager for Marin General Hospital, where bridge victims are brought if there are still signs of life after their extraction from the cold waters of the bay. The trauma pager was never activated in the hours after this event.

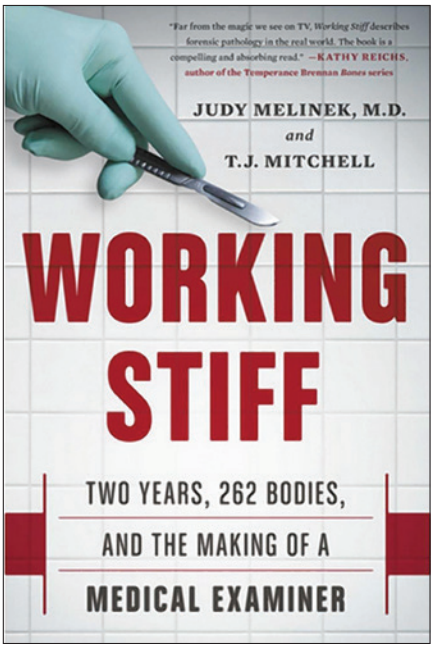
In 2014, the Golden Gate Bridge board of directors unanimously approved the installation of a safety net to deter suicide attempts and raised funds in hopes of beginning construction by late 2017. Thank you to those who have dedicated their time and efforts to erecting a safety barrier on the bridge. Before long, hopefully, events like this will be only a distant memory. ◆

Dr. Maa, a surgeon at Marin General Hospital, is past president of the Northern California chapter of the American College of Surgeons.

Email: maaj@marigeneral.org

Working Stiff and *When Breath Becomes Air*

Sal Iaquinta, MD


"Far from the magic we see on TV, *Working Stiff* describes forensic pathology in the real world. The book is a compelling and absorbing read." —KATHY REICHS, author of the Temperance Brennan *Bones* series
JUDY MELINEK, M.D.
and
T.J. MITCHELL
WORKING STIFF
TWO YEARS, 262 BODIES, AND THE MAKING OF A MEDICAL EXAMINER

Working Stiff: Two Years, 262 Bodies, and the Making of a Medical Examiner (by Judy Melinek, MD, and T.J. Mitchell) is an interesting glimpse into the life of a medical examiner. The author stresses that she worked in the "real world" of Manhattan. She clearly states that in no situation outside of television does a sexy medical examiner show up at the scene of the crime wearing high heels and spouting off subtle clues to the homicide detectives between sexual innuendos and witty remarks.

That might disappoint some readers.

But for those of us who wish Mary Roach had devoted more time to forensics in her fun book, *Stiff*, Dr. Melinek's book fills the void. Don't look for plot or fancy writing. Instead, get absorbed in details that you've never dreamed about. Dr. Melinek isn't solving murders (though there are more than a few homicide victims); she's examining dead bodies day after day. She details the elements of decompensation, the telltale signs of disease or injury, such as how the strap muscles of the neck exhibit different signs depending on whether the person hanged him- or herself or was strangled.

Dr. Iaquinta is a San Rafael otolaryngologist.

Her anecdotes aren't for the faint-hearted and don't make for dinner conversation, but I found them irresistible. I love filling my brain with factoids that I'll never use again . . . that's one of the reasons I went to medical school. So when Dr. Melinek described a case of transfusion-related acute lung injury and a case of anthrax, I was excited. She got to see diseases I'll never see—how cool.

Dr. Melinek gives the book a (living) human touch. From the very beginning she talks about her father's suicide. She draws on that horrible experience when meeting the family members of other suicide victims. The average reader won't be expecting a pathologist who spends time talking to the families of the deceased. There's just enough sentiment in the book to remind us that she's been dealing with real people, not simply giving us disembodied "case reports."

The final chapters focus on September 11, 2001. The book is not in chronological order—this tragedy took place early in her training. But saving it to the end is better, when the reader already understands the lingo and how an autopsy is performed. Her story is one that never quite hit the popular press. No one really wants to know that the Manhattan Medical Examiner's office was overwhelmed and required a series of refrigeration trucks parked outside to hold all the body parts. But we live in a world that is becoming increasingly aware of disaster preparedness, and the Office of the Medical Examiner is part of that response. Even without the unforgettable descriptions of mangled bodies (they found a woman's hand inside the limbless torso of a man), just the logistics of responding to such a mass casualty event are interesting.

Lastly, and unintentionally, the book helps end the battle between dog lovers and cat lovers. In Dr. Melinek's experience, your dog will sit and mourn next to your dead body. Your cat, however, will start eating you within hours of your death.

Paul Kalanithi's *When Breath Becomes Air* is the true story of a young doctor who is diagnosed with Stage IV lung cancer during his final year of neurosurgical residency at Stanford. This is a very different book from *Working Stiff*. *When Breath Becomes Air* is a literary exploration into what is important about life itself.

Dr. Kalanithi's fascination with the brain was lifelong. After getting his master's degree in English, he realizes that writing is a way in which our brains communicate, but the brain itself is the organ that lets us interact with the world. At the same time the brain both has free will and is governed by all the laws of physics. Somewhere biology, morality, literature, and philosophy intersect. And that somewhere is within our skulls. This realization inspires him to become a neurosurgeon. But his time and his dreams are cut short by a deadly diagnosis.

His description of neurosurgical residency is almost unnecessary except for his first brushes with death. His cadaver, a dying patient and a neurosurgeon discussing a dire situation with family members all give him insight into the sacredness of being a physician.

This book's strength is its introspection into what it means to be alive. Paul is given choices at age 36 that most of us will never face. As he undergoes treatment, he realizes that even a great response might mean he will live five to 10 years. He ponders, with a life cut short, what will he do with his remaining time? Should he even bother to finish his training? Finish and get a job? Or should he write? Should he have a baby with his wife? What is really important?

What separates this book from others like it is that he doesn't dwell on the misery of the treatments. Nor does he ponder *Why me?* His answer: *Why not me?* Instead he asks questions like "If the weight of mortality does not grow lighter, does it at least get more familiar?"

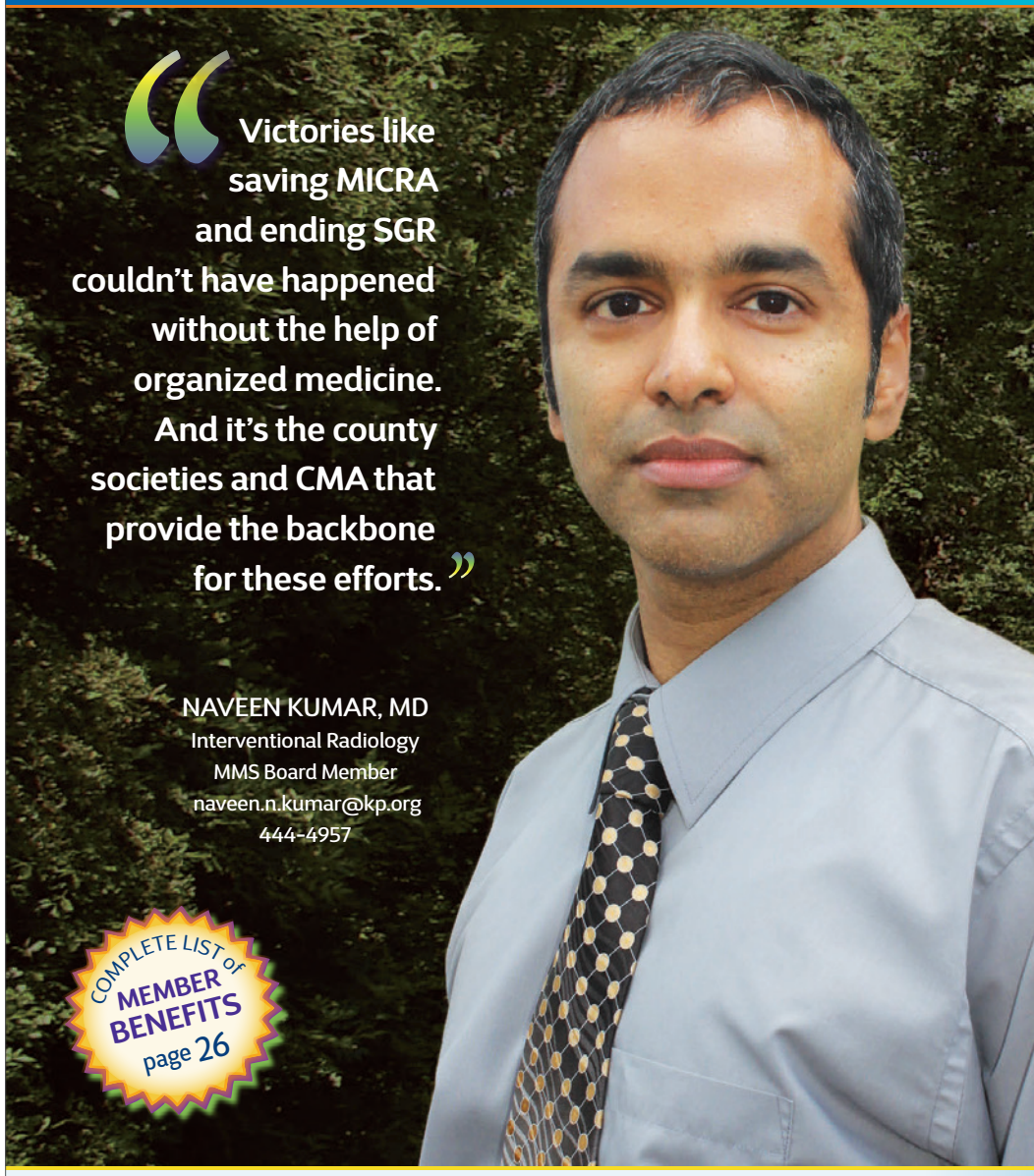
Distilling these two books into one sentence looks like this: *Working Stiff* intrigues the brain; *When Breath Becomes Air* touches the soul. ◆

Email: salvatore.iaquinta@kp.org

MMS CMA

Value of Membership

◆ PRACTICE ◆ PROFESSIONAL ◆ PERSONAL


"Victories like saving MICRA and ending SGR couldn't have happened without the help of organized medicine. And it's the county societies and CMA that provide the backbone for these efforts."
NAVEEN KUMAR, MD
Interventional Radiology
MMS Board Member
naveen.n.kumar@kp.org
444-4957
COMPLETE LIST of MEMBER BENEFITS page 26

Why **PHYSICIANS PRACTICING IN MARIN COUNTY** *should be MMS/CMA members:*

1. By speaking with a united voice, physicians exert a **powerful influence** on the political process at the local, state and national levels. Organized medicine is the "one voice" that legislators and government hear.
2. MMS/CMA worked diligently to **protect MICRA** (Medical Injury Compensation Reform Act), leading a successful campaign defeating Prop. 46 in the 2014 election.
3. **CMA faces down a slew of legal challenges** to the practice of medicine throughout the year, with issues including scope of practice, Medicare audits, peer review and medical staff self-governance.
4. "10 million reasons to be a CMA member." CMA's reimbursement experts have **recouped $10 million** from payors on behalf of physician members over the past five years!
5. MMS is involved in several **initiatives to improve community health**, including access for the uninsured, vaccination, anti-tobacco, oral health, end-of-life issues, safe prescribing of opiates, and much more.

Join MMS/CMA Now! • 415-924-3891 • cmanet.org/membership

TOP 10 REASONS To Join MMS and CMA

Working together, the Marin Medical Society and the California Medical Association are strong advocates for all physicians and for the profession of medicine. Of the many reasons for joining MMS and CMA, 10 stand out:

1 COMMITMENT TO THE PROFESSION

By joining MMS and CMA, physicians affirm their commitment to the profession of medicine and to preserving its honored place in modern society.

2 IMPROVING COMMUNITY HEALTH

MMS is involved in several initiatives to improve community health in Marin County, such as increasing access for the uninsured and bolstering primary care.

3 LEGISLATIVE ADVOCACY

By speaking with a united voice, MMS/CMA members exert a powerful influence on the political process at the local, state and national levels.

4 FOSTERING COLLEGIALITY

MMS and CMA bring doctors from all parts of the medical community together—through leadership, cooperation and social gatherings.

5 FREE MEDICAL-LEGAL INFORMATION

CMA offers free medical-legal information on contracts, subpoenas, employee relations, collections and many other topics.

6 PRESERVING MEDICARE

Thanks to MMS, CMA and other medical associations, recent attempts in Congress to cut the Medicare reimbursement rate have all been rebuffed.

7 PROTECTING MICRA

MMS and CMA work diligently to protect the Medical Injury Compensation Reform Act (MICRA), which safeguards low liability insurance rates for California physicians.

8 PRACTICE MANAGEMENT

MMS and CMA offer a wealth of resources to help physicians manage their practices, implement electronic medical records and qualify for federal incentive payments.

9 STAYING IN TOUCH

Through their magazines, newsletters and websites, MMS and CMA encourage physicians to stay in touch with each other and with current medical news and events.

10 IT'S EASY AND FUN

To join MMS and CMA, go to www.cmanet.org/join. Once you belong, it's fun to get involved in medical society projects and events.

ASK YOUR COLLEAGUES ABOUT MMS AND CMA

One of the best ways to learn more about the benefits of membership in MMS and CMA is to ask your colleagues. The physicians listed below have leadership roles at MMS and would be happy to take your call.

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mwillis@marincounty.org

MMS MARIN MEDICAL SOCIETY

CMA

RIGHT NOW is the best time to join MMS and CMA.

- **Contact Rachel Pandolfi** at MMS: **415-924-3891** or **rachel@marinmedicalsociety.org**.
- **Join online** at www.cmanet.org/membership.

From Death to Medical Satire

The 2016 Western Health Care Leadership Academy welcomed nearly 500 attendees in San Francisco to hear about a range of topics from a dynamic lineup of speakers. These included **Atul Gawande, MD, MPH**, a MacArthur "Genius" Fellowship winner and a *New Yorker* columnist and author; **Bennet Omalu, MD,** the physician who identified chronic brain damage as a major factor in the deaths of NFL players; and entertainer, internist and founder of Turntable Health, **ZDoggMD**.

Dr. Gawande, general and endocrine surgeon, Harvard professor and author of four *New York Times* bestsellers, including *Being Mortal: Medicine and What Matters in the End,* described how he learned to cope with mistakes he made in the operating room as a resident.

"I had to deal with my little imperfections and the complexities of the surgery itself," said Dr. Gawande. Eventually he became comfortable with the surgeries and his own imperfections, but then faced an even more difficult phase of his surgical practice: How to treat those patients who did not do well after surgery.

"What do you do with those patients who do not get better? How do you help patients cope with death?" he asked the audience. "I am a surgeon. I want to fix everything in three hours." But Dr. Gawande said he found his medical education sorely lacking in dealing with mortality. If you've read the articles by Drs. Molly Bourne and Scott Schmidt—"Hospice Is Plain Good Medicine" (page 13) and "RESPECT at the End of Life" (page 17), respectively—Dr. Gawande's observation will sound familiar.

As a forensic pathologist, **Dr. Omalu** dealt with people after death. In his speech, he recounted the story of how he was on call at the coroner's office in Pittsburgh, Pennsylvania, on the Saturday when the body of Pittsburgh Steelers Hall of Fame center Mike Webster was brought into the pathology lab. It was this encounter with Webster that led to Dr. Omalu's discovery—thanks to his independent, self-financed tissue analyses—of chronic brain damage (chronic traumatic encephalopathy, CTE) as a major factor in the early deaths of some NFL veterans. Dr. Omalu is currently the chief medical examiner for San Joaquin County and is a professor in the UC Davis Department of Medical Pathology and Laboratory Medicine. His story inspired a book, *Concussion,* and a 2015 Hollywood movie of the same name starring Will Smith.

The surprise hit of the conference was Las Vegas internist, comedian and rapper **ZDoggMD** (also known as **Zubin Damania, MD**), who entertained and educated the crowd with his unique, insightful and hysterical health care rap parodies. At his ZDoggMD website

Dr. Damania says, "During a 10-year hospitalist career at Stanford, I somehow won clinical teaching awards while simultaneously maintaining a shadow career performing standup comedy for medical audiences worldwide. . . . In Las Vegas, we're making the leap from satire to actionable change by implementing an innovative model of health care delivery." Turntable Health, founded in 2013, is a "membership model, team-based primary care ecosystem." Dr. Damania's TEDMED talk (http://goo.gl/uzvvA4) from the 2013 conference presents a more straightforward version of his ideas.

We had a great time at this year's Western Health Care Leadership Academy. Mark your calendars for another memorable gathering next year in San Diego: May 5–7, 2017. ◆

—Adapted from CMA's May 16 News Release.

Vaccines, Policy and Dialogue in Marin

Matt Willis, MD, MPH

At the end of my first day as a primary care physician in Marin in 2011, I remember being impressed by two common challenges with my new panel of patients. First, I was surprised by expectations of prescription medications as a first-line remedy for ill-defined pain, and second, many of my patients refused the vaccinations I recommended.

I realized my work was cut out for me as a communicator, navigating decisions with patients seeking potentially harmful agents with unproven effectiveness on the one hand, while refusing safe preventive measures on the other.

As public health officer, I see how the challenges experienced in the exam room are manifested on a community-wide scale. Prescription drug abuse and low vaccination rates are two of the most pressing public health challenges facing our community. Fortunately, since 2011, significant progress has been made in both areas. I have focused on prescription drug abuse in prior updates in *Marin Medicine*, and will continue to address the issue as we work to control this epidemic. Less visible, but equally important, has been our progress in vaccinations.

Dr. Willis is Marin County's public health officer.

Under longstanding California law, children enrolling in schools are required to have certain vaccinations. However, the public health benefit of this law has been significantly undermined by an exemption offered to parents opposed to vaccination on the basis of personal beliefs. Marin County had the Bay Area's highest rate of personal belief exemptions (PBEs) to required childhood vaccinations. Of greatest concern is that we have several communities with clusters of unvaccinated school children. In some of these communities, astonishingly, vaccination rates are far below those of some developing countries.

Thanks to a new California law, all Marin communities will be better protected against disease outbreaks. Senate Bill 277, co-sponsored by our pediatrician senator, Dr. Richard Pan of Sacramento, eliminates personal belief exemptions from California law. Starting this year, no incoming kindergarteners will be exempt from required vaccinations without a medical contraindication.

Marin County has been the subject of national media attention regarding vaccinations and vaccine decision-making among affluent, well-educated residents. On national TV, Jimmy Kimmel accused Marin of being "more afraid of gluten than smallpox," and John Stewart said that our PBE rates were the result of "mindful stupidity." Those of us practicing in Marin know the picture is more nuanced than this. In order to help our community adapt to the new law eliminating PBEs and predict its effects locally, it is necessary to understand baseline community beliefs and existing trends.

In 2013, to better understand local vaccination beliefs, Marin County Public Health partnered with the Marin County Office of Education to survey parents of kindergartners from 40 schools. Of the almost 500 parents who responded, 15% had children who were not current on required vaccinations.

We learned from the survey that most families with PBEs actually chose some, but not all, required vaccinations. Some delayed due to concerns about too many vaccines, or believed that the risks of disease are low. Those who categorically refused all vaccinations were a small minority. This is important, because it suggests wide understanding of the value of vaccination even among parents with

PBEs. I trust that these Marin parents can react thoughtfully to the new policy and will choose to expand the protection they already offer their children to the full range of vaccine-preventable diseases.

We also found limited understanding of the communitywide implications of vaccine decision-making. The term "personal belief exemption" is misleading because the effects of opting out of vaccinations are not only personal—they can carry profound consequences for our friends, neighbors and children's classmates. Many parents did not understand that babies younger than 12 months and people who are medically fragile cannot be vaccinated. We learned that we needed to offer stronger messaging about vaccinations as a community responsibility, as something we do not only for our own children, but also for their friends, classmates and neighbors.

Additionally, SB 277 arrived during a trend of increasing vaccination uptake. Perhaps because of a growing understanding of the community benefits of vaccination, or fueled by the 2014 measles outbreak, Marin County vaccination rates began improving even before the new legislation. The PBE rate in Marin has been declining since its peak in 2012. In fall 2015, 6.0% of kindergarteners entering school had a PBE, down from 7.8% in 2012. The last time this many Marin kindergarteners were fully vaccinated was 2007. Still, our opt-out rates remain well over twice as high as the statewide average of 2.3 percent.

While the new law promises to increase vaccination rates among children attending school, it's important to keep in mind that those children who entered school unvaccinated under a PBE in the past can remain in school unvaccinated. It will take several years, as new fully vaccinated cohorts of kindergarteners enter and advance through the grades, before any school—any community—will enjoy the full protection this law is meant to ensure. For this reason, we must remain vigilant for the possibility of preventable outbreaks of childhood diseases.

Before joining the Marin County Health Department, I worked for the CDC, helping control disease outbreaks in the developing world. We failed to control an outbreak of diphtheria in Haiti's tent camps after the devastating 2010 earthquake. In that setting, the spread of disease was a sign of the total disintegration of the local health system and a historical lack of access to safe and effective vaccines. As Public Health Officer, I'm concerned that Marin could end up with similar outbreaks, but for very different reasons. In our case, an outbreak of preventable disease would be the result of choice, through vaccine refusal. Our risk is diminishing significantly thanks to SB 277 and recent increases in vaccine acceptance, but we remain divided—and the risk is still with us.

The so-called "vaccination debate" risks polarizing our community. We want to understand and help address any concerns in the context of three principles: preventable diseases are a real and growing risk; vaccines offer safe, effective protection; and vaccination is a matter of both personal and community responsibility. We unequivocally advocate vaccination as the best, safest way to keep our community free of preventable diseases and want to promote respectful dialogue to this end.

SB 277 is a very positive step. It shows that our community's vaccine decisions are coming into line with Marin's well-established values of prioritizing health. I hope that after being highlighted nationally for low levels of vaccination, Marin can serve as a national model for collective response as we come together to close a gap in our community's health. ◆

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Marin General Hospital: A Bright Future

Gregg Tolliver, MD, MPH

This is an exciting time to be practicing medicine at Marin General Hospital. Construction of our new state-of-the-art hospital has begun, and now that we see some definite changes—a new parking structure and a redesigned hospital entrance for example—clinicians are starting to feel very enthusiastic about practicing in our new facility.

Dr. Tolliver is chief of staff at Marin General Hospital.

As they should! The new building project, called MGH 2.0, will greatly enhance Marin General Hospital's status as the North Bay's premier health care facility. MGH 2.0 consists of twin four-story hospital towers, all private rooms built for patient-centric care, safety and efficiency. The green design includes five new solariums, 13 spacious new operating rooms, an expanded ICU, and state-of-the-art emergency department—triple the size of our present one. With the goal of Marin County's good health in mind, we look forward to the new hospital being completed in 2020. More information and ongoing updates about the project are available on our website, www.mgh2.org.

We are equally enthusiastic about what is going on inside the hospital. Several strategic relationships are bringing the best physicians and resources to Marin General Hospital. We now collaborate with UCSF on four excellent programs: neurosurgery, cardiothoracic surgery, pediatrics and neonatal care. For vascular surgery we teamed up with Stanford Health Care. Marin General Hospital and the Marin Healthcare District work in concert with local physicians to make certain that primary and specialty care (cardiology, urology, endocrinology, internal medicine and vascular surgery) are available in our community. Our

homegrown adult, pediatric and OB-GYN hospitalist programs ensure that the best doctors possible are at the bedside when patients need them most. As an infectious disease physician, I'm proud to work with the dedicated health care providers at Marin County Department of Public Health, Marin Division of Health and Human Services, and Marin Community Clinics to help provide best-quality care for the entire range of patients in our county, from those with the greatest socioeconomic constraints to those with many resources.

We are also excited about the hospital's recent strategic partnership with Royal Philips, a Netherlands-based health care technology company that will provide Marin General Hospital with early and continual access to advanced medical technologies including imaging systems, patient monitoring, telehealth and clinical informatics solutions, as well as clinical education, and consulting and design services. The partnership, the first of its kind between Philips and an independent community hospital in this country, will result in our patients having access to the best technology possible to support their care.

Although our medical staff is independent of hospital administration, we work in concert to ensure that hospital operations are run compassionately, safely and effectively. Hospital administration has vigorously supported new initiatives such as the hospital-wide Operation Safety program, the success of which is reflected in the hospital's third consecutive "A" grade from the Leapfrog Group, an independent industry watchdog organization that rates how well hospitals protect patients from medical errors. Other initiatives include programs to promote hand hygiene and antimicrobial stewardship. We even have a new robot that helps sterilize patient rooms with UV light. We are also very proud of the fact that more than 90% of our hospital staff and physicians were vaccinated against influenza this year. This was no easy task. Many brave staff rolled up their sleeves and got vaccinated for the first time in years. This reflects our organization's growing knowledge that what we do in our hospital has profound effects on the health of the entire population of Marin.

As chief of staff, I'd like to thank the entire medical staff for the compassionate, get-healthy, stay-healthy care they provide the residents of our county. I'd also like to recognize them for the high quality of care they provide. Major rating and accreditation agencies such as Healthgrades, Leapfrog and the Joint Commission continue to recognize us with the highest-level awards for safety and quality. More than 200 of our physicians were named 2015 "Top Docs" by *Marin Magazine* and other regional publications.

These awards and recognitions for exceptional patient care and superiority in clinical excellence showcase the talents and skills of the hospital's physicians and staff as well as reinforce Marin General Hospital's commitment to excellence in patient care and safety.

High-level awards for quality patient care, access to state-of-the-art technology, and a major expansion and modernization project mean Marin General Hospital is well on its way to becoming the North Bay's leading health care destination. For ongoing updates on our journey, visit us at www.maringeneral.org. ◆

Email: tollivg@maringeneral.org

Artist's renderings of the new hospital exterior (left) and main entrance (above).

AMA House of Delegates

Peter Bretan, MD, FACS

During the November 2015 HOD in Atlanta, I had the privilege of sitting with the leadership of our delegation and leaders of other prominent AMA coalitions in four separate in-person forums to discuss national "hot-button" issues—not just what was taking place on the floor of the HOD, but high-priority items for specific state medical societies (SMS). CMA leadership discussed these issues with its counterparts from the three other "Big 4" societies (New York, Florida and Texas) and the Southeast and Heart of America conferences. Together these coalitions represent 60% of all HOD members.

Among the issues discussed were payment models, "balance billing" and "narrow networks," which cause extreme physician shortages and excessive surprise, out-of-network charges. We were all in agreement that neither patients nor physicians should bear these surprise charges since they are caused by insurance companies, which often claim to have complete networks when in reality many of these networks do not provide adequate access to in-network care at contracted hospitals. Networks like these simply should not be sold to health care consumers. One proposed solution to these surprise charges for out-of-network care is to help arbitrate out-of-network cost using the 80th percentile level found on Fairhealth.org published charges. Most are within patient deductibles.

Dr. Bretan, a urologist and transplant surgeon, is a District X alternate delegate to the AMA.

With other AMA factions, such as Southeastern, we discussed SMS governance—for example, the recent downsizing of the CMA Board of Trustees (BOT) from 57 to 35. We noted that most of the smaller societies have BOTs of just 10-15 members. Even the AMA board has only 22 members. The North Carolina and Minnesota societies have abolished their HODs as well, in order to streamline their organizations and cut costs.

While this would not work for California, our new system of year-round resolution submissions, with testimony and BOT decisions made every quarter, will enable our HOD to more easily handle the review of the 250 annual resolutions during the shortened (from three days to two—leading to a 37% cost reduction) in-person HOD meeting. Most importantly, it has made possible more online testimony.

Maintenance of Certification (MOC): There was extensive testimony at the HOD that the cost of MOC as run by the American Board of Internal Medicine (ABIM) is "out of control," with the cost of recertification sometimes exceeding $20,000 a year. In Georgia, MOC is accomplished simply with CMEs. Several large hospital systems have approved the newly formed National Board of Surgeons and Physicians (NBSAP) as their MOC-accrediting body. Dr. (and Senator) Rand Paul is starting his own ophthalmology board.

Medicaid expansion in California resulting from ACA is about 1.4 million new patients. Across the state, physician revenues are down 30–40%. Here physicians are the losers, but this may be less related to Medicaid expansion than to insurance issues and artificially induced physician shortages caused by narrow networks. Kentucky, a "red state," enjoys Medicaid expansion brought about by its state exchange, which is called "Not Obama Care."

Code Modernization: Currently, the Council of Ethical and Judicial Affairs (CEJA) can only modify the code all at once, which is very inefficient, as every meeting for the past six years has not been able to produce a finished product. Dividing this task into sections should be more efficient. Several coalitions wish to collaborate in this process. Unfortunately, CEJA has authority over the final product, and the HOD enjoys only advisory status in the modernization process. Nevertheless, HOD approval is required for code ratification. A call for process change, in which CEJA seeks code modernization, was brought forth by our California delegation and is gaining traction.

Other issues were discussed in debating resolutions—for example EMR-Meaningful Use burdens on physicians, asking CMS for a delay in implementing the penalty phase of compliance, and a call to defund IPAD through MACRA (Medicare Reform Law and CHIP Reauthorization Act of 2015). The outcome of all significant resolutions can be found in the AMA Proceedings (http://goo.gl/mcVjZn).

As a member of the California delegation to the AMA, I have learned a great deal in the past 15 years. For example,

Health Care Policy (HCP) is never an accident, easy or simple. It is forged by dedicated leaders in the CMA and AMA. How your leaders work at each HOD is truly an amazing democratic process. Your California delegation to the AMA is in the forefront of the discussions that help mold health care policy at both state and national levels. These policies often lead to laws. HCP also helps senators and representatives in Congress understand the thinking that goes into our very transparent process. The California delegation works hard for all of our practices in this time of rapid, difficult change. It fights to keep our profession independent of the purely financial forces that motivate large corporations. However, our delegation's strength in accomplishing anything nationally depends on your membership. Please continue your generous support of our CMA and consider joining the AMA, since together we are stronger. ◆

Email: bretanp@msn.com

The California delegation to the AMA consists of almost 50 physicians, about 10% of the AMA's total House of Delegates membership, making it the organization's largest delegation. Delegates are elected by CMA delegates who are also AMA members. Each district is entitled to elect at least one delegate and alternate, as well as additional delegates for every 1,000 AMA members in that district. The AMA HOD meets every six months—in Chicago every June for five days and again in November for four days in rotating cities. Last fall, this "interim" meeting was held in Atlanta. I have been helping represent District X at the AMA since 2003.

The CMA leads the AMA's Pacific Rim Coalition, which also includes Alaska, Hawaii and Guam. Until 20 years ago it also included Oregon and Washington. However, those state societies' delegates elected to leave the Pac Rim Coalition for perceived lack of representation. Nevertheless, talks have been taking place for the past 10 years to bridge this divide, and in the past month the talks have successfully led to the reconstitution of the PAC Rim Coalition. This will help it be more effective in determining AMA national health care policy and legislative matters.

Donate Today!

Shape Local Health Policy by Supporting MMPAC

Your support is needed to ensure that the Marin Medical Society (MMS) continues to be an effective advocate on your behalf on local and state health care issues.

Through the MMS's political action committee—MMPAC—the MMS is able to support candidates for local office who are responsive to our concerns about health care issues in Marin. Often the impact of this support goes far beyond our local community, as these candidates move on to higher office in Sacramento.

MMPAC-supported candidates look to MMS for input on vitally important local health care issues. MMPAC's success is dependent on your support.

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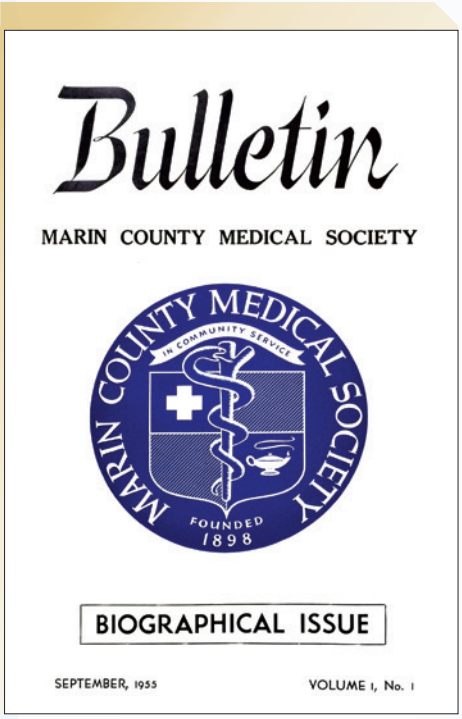
Questions? Call Rachel at **415-924-3891.**

MMPAC is a voluntary political organizaton that contributes to candidates for local office. Political law and MMPAC policy determine how your contribution to MMPAC is allocated. A decision not to contribute to MMPAC will not affect your membership status with the MMS. MMPAC is sponsored by the Marin Medical Society. Contributions are not deductible for income tax purposes.

Marin Medicine Marks Six Decades

Cynthia Melody, MNA



Founded in 1898, the Marin County Medical Society issued its first publication 57 years later, in September 1955. According to Dr. Carroll A. Russell, the Society's president at the time,

> The officers of the Marin County Medical Society have considered publishing this type of bulletin for some years, and we feel that the recent rapid increase in our membership has made it imperative for some type of publication as means for disseminating information and keeping each member posted about our ever-expanding activities. We realize that our *esprit de corps* is extremely high, and we know the quality of the medical profession in Marin County is outstanding. Let us make this *Bulletin* reflect those high standards.
>
> —*Bulletin*, Sept. 1955, Vol. 1, No. 1.

As we celebrate the 60th anniversary of the Marin Medical Society's publication, the 2015-16 board of directors is proud to share this retrospective look at the many changes and modifications that have occurred over the years. ◆

1955 *Bulletin of the Marin County Medical Society*

The first Bulletin *featured a short biography of all medical society members to help everyone become better acquainted. Interesting and informative, the 6- by 9-inch monthly magazine, with a blue logo emblazoned on the cover, was primarily intended to be a scientific journal.*

1967 *Marin Bulletin*

The Marin Medical Society logo began being printed with a vertical band, and in a different color with each month's issue.

1972 *Marin Physician*

The magazine got a new name, and the cover now featured a black-and-white photograph of Marin or of seasonal changes in Northern California.

the new marin physician
A PUBLICATION OF THE MARIN MEDICAL SOCIETY
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AMA Membership will be Optional in California
$39.2 Million in 1975 for Malpractice Claims
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The NEW Marin Physician

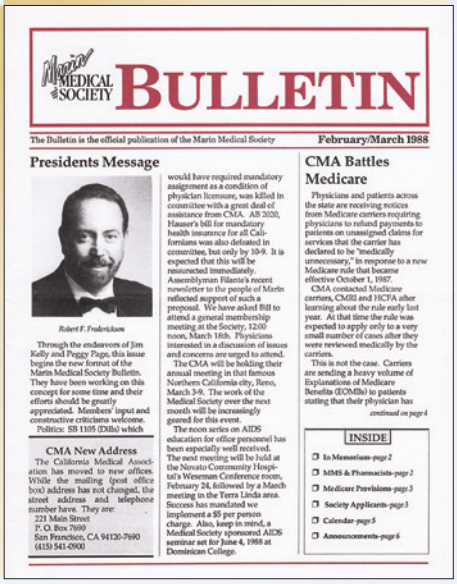
1976 *New Marin Physician*

A new name and format replaced Marin Physician, *which ceased to be issued in 1974. The new publication was published monthly in tabloid-newspaper format.*

Marin Medical Society
BULLETIN
1983
A Year of Change and Challenge

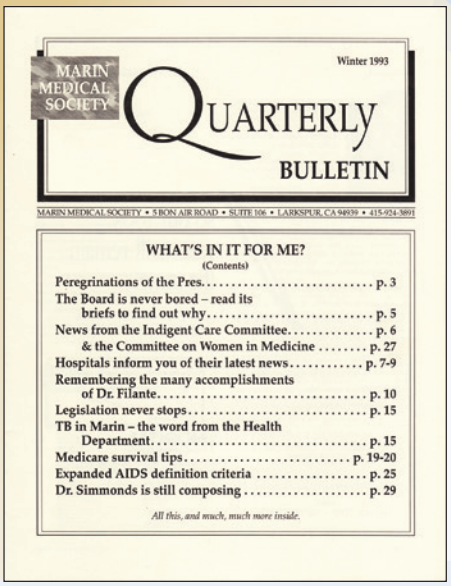
1983 *MMS Bulletin*

Change continued with another new title and format. Still published monthly, the new Bulletin *was an 8.5- by 11-inch newsletter.*


Marin Medical Society
BULLETIN
The Bulletin is the official publication of the Marin Medical Society
February/March 1988
Presidents Message
CMA Battles Medicare
CMA New Address
INSIDE

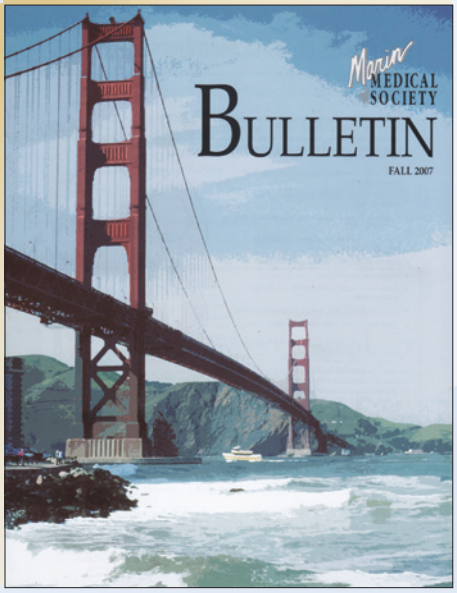
1988 *MMS Bulletin*

The newsletter saw a slight change to the masthead with a new logo.


Marin Medical Society
QUARTERLY
BULLETIN
Winter 1993
WHAT'S IN IT FOR ME?
(Contents)

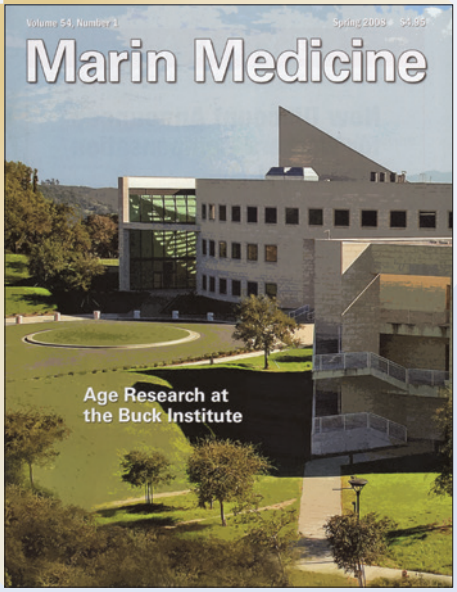
1993 *MMS Quarterly Bulletin*

Another adjustment to the masthead identified the publication as a quarterly.



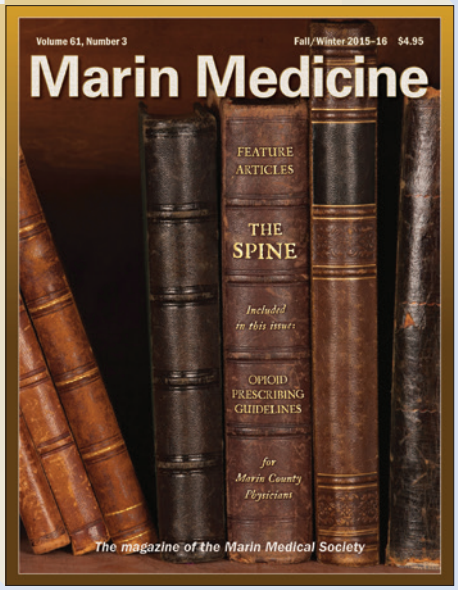
2007 *MMS Bulletin*

A new era was born as the publication underwent a metamorphosis and emerged as a full-color quarterly magazine.



2008 *Marin Medicine*

The title was changed to reflect a wider audience and to appeal to advertisers. Each issue featured a topic of interest with articles written by and for physicians.



2015 *Marin Medicine*

In its 60th year, the magazine began a semi-annual publication schedule.

Ms. Melody is executive director of the Marin Medical Society.
Email: cmelody@scma.org

WELCOME NEW MMS MEMBERS!

Robert Newbury, MD, Critical Care Medicine*, 75 Rowland Way #100, Novato, Boston Univ 1991

Gygory Pataki, MD, Internal Medicine*, 99 Montecillo Rd., San Rafael, Med Univ Pecs (Hungary)

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MMS members can place FREE classified ads in *News Briefs* or *Marin Medicine*. Cost for nonmember physicians and the general public is $1 per word. To place a classified ad, contact Susan Gumucio at **susan@scma.org** or **707-525-0102.**

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